STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

MISSOURI FETAL DEATH FACILITY WORKSHEET

MOTHER'S MEDICAL RECORD #	MOTHER'S NAME	
DATE OF DELIVERY	PLURALITY	BIRTH ORDER

Questions 1-4 are not shown on this worksheet. These fields are default hospital information stored in the MoEVR program.

PRENATAL

5. Place of delivery:

- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home birth
  Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's Office
- ☐ En route
- ☐ Other (specify) _____

6(a). Date of first prenatal care visit

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

☐ No prenatal care

6(b). Date of last prenatal care visit

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

7. Total number of prenatal care visits for this pregnancy

_____ Number ☐ No visits

8. Date last normal menses began

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

9. Number of previous live births now living

_____ Number ☐ None

10. Number of previous live births now dead

_____ Number ☐ None

11. Date of last live birth

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

12. Total number of other pregnancy outcomes

_____ Number ☐ None

13. Date of last other pregnancy outcome

__ __ / __ __ __ __
M M Y Y Y Y

14. Risk factors in this pregnancy (*check <u>ALL</u> that apply)*

Diabetes: (specify)
- ☐ Prepregnancy
- ☐ Gestational
- ☐ Insulin Dependent

Hypertension: (specify)
- ☐ Prepregnancy
- ☐ Gestational
- ☐ Eclampsia

- ☐ Previous preterm births
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; if YES, check all that apply:
  - ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - ☐ Assisted reproductive technology
- ☐ Mother had a previous cesarean delivery; if YES, how many? _____
- ☐ None of the above

15. Infections present and/or treated during this pregnancy– *check <u>ALL</u> that apply*

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ HIV
- ☐ Hepatitis C
- ☐ Hepatitis B
- ☐ Listeria (LM)
- ☐ Group B Steptococcus (GBS)
- ☐ Cytomegalovirus (CMV)
- ☐ Parvovirus (B19)
- ☐ Toxoplasmosis (TOXO)
- ☐ Zika Virus
- ☐ None of the above
- ☐ Other (specify) _____

_____

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LABOR AND DELIVERY

16. Mother's weight at delivery
_____ pounds

17. Characteristics of labor and delivery - *check ALL that apply*
☐ Induction of labor

18. Method of delivery
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No
C. Fetal presentation at birth - *check ONE:*
☐ Cephalic ☐ Breech ☐ Other
D. Final route and method of delivery - *check ONE:*
☐ Vaginal / Spontaneous
☐ Vaginal / Forceps
☐ Vaginal / Vacuum
☐ Cesarean: if yes, was a trial of labor attempted?
☐ Yes ☐ No
E. Hysterotomy/Hysterectomy? ☐ Yes ☐ No

19. Maternal morbidity - ***check ALL that apply***
☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above

20. Attendant (individual physically present at the delivery who is responsible for the delivery):

Name: _____

NPI: _____

Title: ☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ Other midwife
☐ Other (specify) _____

21. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
If yes, enter the name of the facility mother transferred from:

_____

22. Principal source of payment for this delivery (at time of delivery):
☐ Private insurance
☐ Medicaid
☐ Self-pay
☐ Other (specify) _____

FETUS

23. Date of delivery:
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

24. Time of delivery: _____ ☐ a.m. ☐ p.m.

25. Weight of fetus: _____ **grams** or _____ **lb/oz**

26. Obstetric est. of gestation at delivery (comp wks): _____

27. Sex: ☐ Male ☐ Female ☐ Undetermined

28. Plurality (single, twin, triplet, etc.): _____

29. If not single birth, order delivered in the pregnancy: _____ **and number of fetal deaths in this delivery** _____

30. Congenital anomalies of the newborn - *check ALL that apply*
☐ Anencephaly
☐ Microcephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect
☐ Cleft lip with or without cleft palate
☐ Cleft palate alone
☐ Down Syndrome:
☐ Karyotype confirmed ☐ Karyotype pending
☐ Other chromosomal disorder:
☐ Karyotype confirmed ☐ Karyotype pending
☐ Hypospadias
☐ None
☐ Other (specify) _____

31. Method of disposition
☐ Burial
☐ Cremation
☐ Hospital Disposition
☐ Donation
☐ Removal from State
☐ Other (specify) _____

32. Cemetery

Name: _____

Location: _____
City or Town

_____
State

33. Date of disposition
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

34. Disposition facility:
Name: _____
Number & Street: _____
City or Town: _____
State: _____ Zip: _____

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MISSOURI FETAL DEATH FACILITY WORKSHEET

CAUSE OF DEATH

Causes/Conditions Contributing to Fetal Death:
Previous questions collected details on anomalies, morbidities, and risk factors known to be present for this patient and the fetus. The purpose of the next section is to get a description of those conditions that, in your opinion, contributed to the fetal death. Please report any condition judged to be a cause of death even if it has been reported elsewhere on the worksheet.

35. Initiating Cause/Condition:
Among the choices below, please select the ONE which most likely began the sequence of events resulting in the death of the fetus. If it is not clear to you where to report a condition, write it on the "(Specify)" line that seems most appropriate.

Maternal Conditions/Diseases

(specify) _____

_____

Complications of Placenta, Cord or Membranes

- ☐ Rupture of membranes prior to onset of labor
- ☐ Abruptio placenta
- ☐ Placental insufficiency
- ☐ Prolapsed Cord
- ☐ Chorioamnionitis
- ☐ Other (specify) _____

Other Obstetrical or Pregnancy Complications

(Specify) _____

_____

Fetal Anomaly

(Specify) _____

_____

Fetal Injury

(Specify) _____

_____

Fetal Infection

(Specify) _____

_____

Other Fetal Conditions/Disorders

(Specify) _____

_____

☐ Unknown

36. Other Significant Causes or Conditions: Select or specify all other conditions contributing to death in Item 35.

Maternal Conditions/Diseases

(specify) _____

_____

Complications of Placenta, Cord or Membranes

- ☐ Rupture of membranes prior to onset of labor
- ☐ Abruptio placenta
- ☐ Placental insufficiency
- ☐ Prolapsed Cord
- ☐ Chorioamnionitis
- ☐ Other (specify) _____

Other Obstetrical or Pregnancy Complications

(Specify) _____

_____

Fetal Anomaly

(Specify) _____

_____

Fetal Injury

(Specify) _____

_____

Fetal Infection

(Specify) _____

_____

Other Fetal Conditions/Disorders

(Specify) _____

_____

☐ Unknown

37. Was an autopsy performed?
☐ Yes ☐ No ☐ Planned

38. Was a histological placental examination performed?
☐ Yes ☐ No ☐ Planned

39. Were autopsy or histological placental examination results used in determining the cause of fetal death?
☐ Yes ☐ No

40. Estimated time of fetal death

- ☐ Dead at time of first assessment, no labor ongoing
- ☐ Dead at time of first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death